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Editorial

On Case and Deaton's deaths of despair: implications for health inequalities research in the post-COVID-19 era

Sobre la muerte por desesperacion de Case y Deaton: implicaciones para la investigación sobre desigualdades en salud en la era post-COVID-19

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Anne Case and Angus Deaton's *Deaths of Despair* volume[1] deals with a stark public health and social problem that affects working class whites —but not only— in the United States and other Western wealthy liberal democracies. Despite the severity of this problem, except for a handful of authors who investigate it, this significant concern managed to stay under the radar for a long time. Deaths of despair refer to the midlife deaths among white persons who hold a high school diploma or less, and which are associated with drug overdoses, alcohol-related diseases, and suicide.[1] When combined with sluggish progress in the fight against heart disease and cancer, such deaths lead to not only distress and suffering but a significant increase in mortality among this population.[1] To worsen this forecast, the increase in midlife mortality rates further amplifies the existing gaps in mortality rates between social classes, and between extremes of wealth and poverty.[1] In this critique, we do not question the phenomenon of increased deaths among working class whites, but we question the emphasis on it compared to ongoing racialized health crises, and we question the psychosocial explanations for it.

Although deaths of despair have received increased attention in recent years, they are not new. Case and Deaton hypothesize that the rise in deaths of despair corresponds to a gradual build-up —over four decades of economic decline— of pain, suffering, and shattered worldview among white working-class Americans. The process began in the 1970s, with the decline of the United States manufacturing sector, and continued over the course of at least three major financial and social crises.[1] The current global economic recession set in motion by the COVID-19 pandemic supplies more examples of the close links between economic crises, increased unemployment, and mental health disorders, including alcohol and drug abuse and suicide.[2]

Despair all around: accounts for the recent United States mortality surge

Chase and Deaton's deaths of despair are discussed in the context of a sustained increase, recorded since the early 2000s, in mortality rates among whites who lack a college degree, in contrast to the decrease in (a) mortality rates among Blacks and Latinx, no matter their level of education,[1] (b) mortality rates in general in countries with similar levels of economic development[1], and (c) mortality rates for older individuals.[3]

Explanations for the phenomenon

A preliminary explanation for the difference in mortality outcomes among whites without college degrees is *cumulative disadvantage,* which is hypothesized to affect whites with low levels of education and the later generations of their offspring.[1] Such disadvantage would be precipitated by a weakening of unions and resulting loss of worker power, along with limited labor market opportunities.[1] Employment opportunities continue to worsen steadily for whites with low levels of education, changing not only their participation in the labour market but, later, their social relationships including marriage rates and child outcomes[1].

Another explanation for deaths of despair is the *lack of a comprehensive social safety net* in the United States, such as universal health care or adequate unemployment compensation. Such policies would mitigate the impact of economic decline and economic crises on the most adversely affected population sub-groups, who would otherwise experience increases in negative health outcomes, including mental disorders.[1] For example, researchers found that suicidal behaviour following the 2007-2008 economic crisis was attributable to high unemployment rates and job loss affecting working-aged men.

Yet, the documented increase in deaths of despair and overall mortality rates was not exclusive to less-educated whites. For instance, a longitudinal study using a nationally representative United States sample, consisting of whites, Blacks, and Latinx who were adolescents in 1994, concluded that indicators of despair —mental health and substance use— increased in the sample as it progressed towards midlife, independent of race or ethnicity, education, and geographical location in rural or urban areas.[4] These findings suggest that the midlife mortality rates for these racialized groups could be on the rise as well.

Similarly, an analysis focused on midlife deaths in the United States between 1959 and 2016 concluded that the increase in life expectancy slowed gradually over time and actually began to decrease after 2014.[5] The increase in midlife deaths experienced by all racialized groups, including whites, Blacks, and Latinx, which

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contributed to the decrease in life expectancy, was linked to drug overdoses, alcohol use, and suicides, along with several conditions such as obesity, high blood pressure, renal failure, endocrine, neurologic, and other body system disorders.[5] Moreover, it is well known that Black residents of segregated and impoverished neighbourhoods are exposed to unemployment, poor living conditions, drugs, and violence, factors which co-exist and amplify each other's effects, leading to negative health outcomes which, in turn, lower their life expectancy. Finally, decreases in life expectancy and increase in midlife death rates also affect white women, not only white men.[1,3]

Challenges to the deaths of despair hypothesis

The evidence summarized above leads us to challenge the deaths of despair hypothesis offered by Chase and Deaton (i.e., that the increase in mortality rates linked to drugs, alcohol, and suicide in the United States stems from a shattered worldview following the degradation of living and working conditions among United States working class whites). We organize our criticism of the deaths of despair hypothesis into three categories that we examine below.

Exclusive focus on the white working class

While the white working-class population experienced downward mobility in the decades of neoliberal globalization, so too did working-class racialized groups (Blacks, Latinx, Native Americans). Evidence points to negative health effects of downward mobility among racialized working class communities during recent decades as well (i.e., the AIDS and Crack Syndemic in the 80s and 90s, but also the heroin epidemic, homicide, and infant mortality among Blacks in the 60s and 70s[6]).

In fact, the pattern of lower life expectancy among United States racialized and ethnic minority populations is constant in working class history —including the current COVID-19 pandemic— and reflects the racialized structure of the United States capitalism.[6] From this perspective, the emphasis of the deaths of despair hypothesis on United States whites —their shattered worldview leading to suffering and suicide among— is in stark contrast with explanations mobilized for health crises of the racialized working class in prior decades, including victim-blaming biological determinism, criminality, and moral deficits.[6]

It seems plausible that a shattered worldview, wherein the United States white working class perceived itself as a world leader in wellbeing and ahead of other racialized and ethnic groups in the United States and abroad, might underlie the deaths of despair phenomenon. Yet, emphasis on these psychosocial determinants diverts attention from economic and political determinants; for example, labor market explanations such as the rise of flexible or precarious employment in earlier decades in the same states where deaths of despair are observed.[7] In addition, such claims also divert attention from the austerity measures adopted following the 2007-2008 economic crisis that included severe cuts to welfare payments, social services, housing and public transport subventions, and public health care spending which, in turn, were associated with rises in the number of untimely deaths of citizens affected by downward mobility in most wealthy countries, including the United States. Within this line of criticism, the deaths of despair phenomenon is a partial truth that conceals the larger systemic structure of social determinants of health inequalities in the United States.

Validity of the link between opioid deaths and despair

Several authors and reports suggest that the overdose epidemic in the United States is partially caused by the low-cost and wide-availability of drugs and not due to a worsening of economic conditions.[8] Another line of reasoning attributes the rise of overdose deaths to the introduction in the United States market of fentanyl, whose comparative abuse potential (similar to cocaine or methohexital) was discovered in the 1980s.[9] While in the last decades of the 20th century fentanyl was mostly used as an anesthetic in surgery, it was massively introduced in the illegal market after prescription opioids such as Oxycontin© peaked in the early 2010s.[1] Therefore, for prescription opioid and heroin users who shifted to cheaper and more available synthetic fentanyl, overdose deaths might be deaths of toxicity rather than despair.

Conclusion

Despite the compelling explanation of the psychosocial effects of downward mobility among midlife working class whites, we recommend caution towards its embrace, as an inflated focus on the shattered worldview of this segment of the United States population might distract researchers from the current effects of political and economic discrimination, segregation and oppression among racialized and ethnic working class minorities in the post-COVID-19 era.[7]

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